» CHAPTER 12 »

Assertiveness Training

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Background/History

Assertiveness has been described as a trait, a behavioral style, a communication style, and a skill to promote positive relations and self-esteem. Salter (1949) described assertiveness as a trait someone was born with. However, scholars later acknowledged that assertiveness is a skill that can be learned. Bedell and Lennox (1996) define assertiveness as an interpersonal behavioral approach "that simultaneously attempts to maximize the person's satisfaction of wants while considering the wants of other people, thus promoting respect of self and others" (p. 132). Alberti and Emmons (2001) defined assertiveness as a behavior which "enables a person to act in his or her own best interest, to stand up for himself or herself without undue anxiety, to express honest feelings comfortably, or to exercise personal rights without denying the rights of others" (p. 13). They also distinguish assertive responding behavior from nonassertive and aggressive styles of responding. Paterson (2000) described assertiveness as one of several styles of interpersonal communication. The other styles he described include passive, aggressive, and passive-aggressive.

Assertiveness is a concept that has its roots in early behavioral therapy. Salter (1949) and Wolpe (1958) both recognized that some individuals had specific difficulties standing up for their rights. Assertiveness skill-development strategies were used to help these individuals function better in everyday life (Bedell & Lennox, 1996, p. 268). In his 1949 publication, *Conditioned Reflex Therapy*, Salter described several prescribed response styles. He called these styles the "excitatory reflexes." These reflexes, or responses, were used in the treatment of a wide variety of symptoms, such as claustrophobia, shyness, low self-sufficiency, depression, sexual problems, psychosomatic problems, stuttering, and alcohol addiction (Colter & Guerra, 1976; Salter, 2002). Wolpe, a behavioral therapy pioneer, recognized assertiveness training for its ability to reciprocally reduce anxiety (Bedell & Lennox, 1996). Assertiveness training became popular with women in the 1970s as a way for them to be informed about their interpersonal rights, overcome their internal barriers to change, and negative socialization ("Assertiveness Training," 2003; Enns, 1992).

Alberti and Emmons (2001) noted that in terms of assertiveness, individuals are characterized as either "situational nonassertive/aggressive" or "generalized nonassertive/aggressive." The situational nonassertive/aggressive individual can be a relatively healthy person who, with or without professional help, may learn to successfully initiate more assertive behaviors. However, the generalized nonassertive/aggressive individual will probably require some form of professional attention in order to overcome his or her behavioral deficits related to assertion. Therefore, the generalized nonassertive/aggressive type person is the best candidate for assertiveness training.

Intended Client Groups

Assertiveness as a behavioral or communication response and assertive training programs have been utilized and studied for a variety of populations, such as:

- individuals with physical disabilities and wheelchair users (Glueckauf & Quittner, 1992; Page, Holland, Rand, Gartin, & Dowling, 1981)
- individuals with visual impairments (Hersen & Kabacoff, 1995; Kim, 2003; Kolb, 1985)
- individuals with chronic pain (Winterowd, Beck, & Gruender, 2003; Zelik, 1984)
- individuals with eating disorders (Shiina et al., 2005)
- at-risk youth who demonstrate difficulties with interpersonal communication (Laxton, Gray, & Watts, 1997; Shannon, 1999)
- victims of violence and abuse (Brecklin & Ullman, 2005; Meyer, 1999; Ticoll, 1994)

- marginalized groups such as women and the elderly (Doty, 1987; Ryan, Anas, & Friedman, 2006; Davidson, 1997; Jakubowski-Spector, 1973)
- individuals with mental illness, especially those who have depressed or suicidal ideation (Douglas, 1980; Lin et al., 2008; Arean, Nezu, & Nezu, 1991; Weinhardt, Carey, Carey, & Verdecias, 1998)
- adolescents susceptible to peer pressure to drink alcohol, smoke, ingest illegal drugs (Goldberg-Lillehoj, Spoth, & Trudeau, 2005)
- individuals with substance addictions (Clark, 2000; Heinemann, 1993)
- participants with disabilities in a sheltered workshop (Page et al., 1981)
- residents of institutions such as nursing homes and hospitals (Segal, 2005)
- school children at-risk for bullying (Crothers & Kolbert, 2004)

Basic Premises

Assertiveness Training (AT) is a form of behavioral therapy with a long history of use in personal growth groups and mental health treatment ("Assertiveness Training," 2003). AT has roots in the women's movement and in treating individuals with various mental health conditions. During the 1970s, the use of assertiveness training with people with disabilities broadened. The recognition of assertiveness training as a method to build self-esteem, to improve communication of needs, and to empower people with disabilities facilitated the increased use of assertiveness training with diverse populations and in a variety of service settings ("Assertiveness Training," 2003; Ruben & Ruben, 1989).

Assertiveness training has been described as an intervention that explores and develops personal techniques for positive verbal communication and preferred behavioral responses which lead to better interpersonal relations (Dombeck & Wells-Moran, 2006; Kim, 2003). It has been touted as a process for communicating feelings, improving self-esteem, and empowering individuals who have traditionally been marginalized (Austin, 2004; Davidson, 1997; Kolb, 1985; Shiina et al., 2005). As a treatment intervention, assertiveness training provides a mechanism for coping with the social anxiety and the emotional barriers that may interfere with recovery and successful community reintegration (Douglas, 1980; Glueckauf & Quittner, 1992; Heinemann, 1993; Lin et al., 2008; Zelik, 1984). According to the *Encyclopedia of Mental Disorders*, the main premise of assertiveness training is "to teach people strategies for acting on their desires, needs, and opinions while remaining respectful of others" ("Assertiveness Training," 2003).

Wolpe and Lazarus (1966) described methods of assertiveness training as including behavioral methods such as modeling, shaping, and autofeedback. In their *Handbook for Communication and Problem-Solving Skills Training*, Bedell and Lennox (1996) outlined a framework for assertiveness training that includes sections on the verbal and nonverbal components of assertiveness, in addition to addressing the consequences of assertive responses. They describe a four-component process of training including (a) instruction, (b) supervised practice, (c) feedback, and (d) independent practice. Alberti and Emmons (2001) recommend that the content of an assertiveness-training program contain both behavioral rehearsal and cognitive rehearsal components. The behavioral rehearsal components include definitive behaviors that lead to assertive response (e.g., refusing a request, expressing emotions, and defending oneself). Cognitive rehearsal modifies attitudes and beliefs that could undermine assertiveness (e.g., self-defeating descriptions, reasoning, and thought modification).

"Being There" is an assertiveness program designed by professionals at Changeways Clinics in Vancover, Canada that uses a psychoeducational group therapy approach. This program consists of 8 to 10 sessions (2 1/2 hours each) addressing a range of 12 topics on assertiveness. The topics include: (a) definitions of assertive, passive, aggressive, and passive-aggressive; (b) barriers to assertiveness; (c) assertiveness rights; (d) nonverbal behavioral styles; (e) giving opinions; (f) accepting compliments; (g) coping with criticism; (h) giving constructive negative feedback; (i) saying no; (j) making effective requests; and (k) dealing with confrontations. *The Assertiveness Workbook* (2000), authored by Randy Paterson, is based in part on the "Being There" program. He provided information, self-assessments, writing exercises, and practice suggestions to the reader for a self-help approach to assertiveness training.

Zelik (1984) described an assertiveness program for patients with chronic pain. The goals of this program include: (a) to enhance patient understanding of the role of stress in their lives and how assertiveness can reduce stress, (b) to teach assertiveness concepts and role-playing situations that they can incorporate these concepts into their lives, and (c) to assist patients in recognizing their behavioral response styles and how to change negative behaviors to assertive behaviors. The program consisted of 6 hours of classroom

instruction, including theory, discussion, and practice through role-playing. Assertiveness training was introduced after 2 weeks of a 5-week inpatient admission. The program incorporated handouts, practice sheets, and a bibliography of readings. The content of the training included defining key concepts such as passive, assertive, aggressive behaviors; discussing the relationship of stress and pain; the importance of nonverbal communication and listening skills; dealing with potential anger issues through conflict resolution; and role-playing specific situations where assertive responses would be the preferred. As part of an interdisciplinary plan of treatment, this program was rated favorably by patients in terms of gaining control over their pain, increasing their ability to handle stress, and improving communication skills.

Teaching assertiveness skills to people with learning disabilities was the goal of a program implemented by Laxton, Gray, and Watts (1997). This program consisted of 24 group sessions covering five main areas: (a) improving self-esteem, (b) identifying and labeling feelings, (c) rights and responsibilities, (d) passive, aggressive, and assertive behavior, and (e) presentation of knowledge and skills to others. Activities utilized in the training program included self-drawings, audio tape recordings, videos, behavioral rehearsal, feedback, games, relaxation sessions, role plays, and open discussions. A unique feature of this program was that, at the conclusion of their sessions, the participants planned and implemented a presentation on assertiveness to their family members and the agency staff. The intent of this presentation was to facilitate the support of family and staff for practicing and maintaining the assertive skills they learned through the program. Pre- and post-questionnaires, along with weekly session evaluations, were used to evaluate the program. These sources of evaluation indicated overall program success with the final presentation being rated as the most positive aspect of the program.

Several models of response have been used to teach assertiveness strategies. The assertive model DESK described by Shannon (1999) is proposed as part of a program to teach children to effectively express themselves. DESK is an acronym: "D," describe the behavior; "E," express feelings using the "I" message; "S," state what the complainant wants the listener to change; "K," know what the listener will not change. To be most effective, it is recommended that both the complainant and listener are trained in the use of this model. In a similar vein, Davis (1998) proposed the use of the formula DESC as a format for assertion. This formula directs the use of "I messages" in a systematic and detailed way. DESC is an acronym for "D," describe the situation; "E," express your feelings regarding the situation; "S," specify the change that you desire; "C," identify the consequences that could occur. These are important strategies for individuals to organize an assertive response.

Another common assertiveness-training strategy is to teach individuals about their "rights" and how to stand up for their rights without infringing on the rights of others (Alberti & Emmons, 2001; Hermes, 1997; Paterson, 2000; Smith, 1975). The application of the "I" message versus the "you" message is a concept used to reinforce this strategy. An "I" message focuses on the person taking responsibility for their feelings and needs and expressing them. The "I" message is preferred to a "you" message that puts responsibility for feelings on others and begets blame. Hermes (1998, p. 21) proposed the use of the "Assertiveness Formula" as a tool in reinforcing the use of "I" messages. The formula is as follows:

I feel _____

When you _____

Because _____

I want/need _____

In her book *Assertiveness: Practical skills for positive communication*, Hermes provides worksheets to practice applying this formula in various life circumstances (1998, pp. 21–24). The focus on "I messages" is an important aspect of providing assertive responses. (See also Chapter 5 on Communication Techniques in this text.)

Related Research

Aspects of assertiveness training are often incorporated into interdisciplinary treatment programs and/or TR interventions, such as social-skill training, anger management, stress management, and/or community reintegration programs (Clark, 2000). However, more specific AT programs have been described in the literature and in research studies testing its efficacy.

Glueckauf and Quittner (1992) designed an assertiveness-training program for individuals who use wheelchairs. The program consisted of 11 sessions addressing a variety of topics: (a) introduction; (b) distinguishing among passive, aggressive, and assertive behaviors; (c)

practice of basic listening skills; (d) providing feedback and managing awkward disability-related situations; (e) ineffective thinking and identification of assertive rights; (f) practice of autogenic and progressive relaxation techniques; (g) expressing frustration and anger in an assertive fashion; (h) implementation and practice of individual assertion goals; (i) group practice of assertion goals; and (j) social networks and termination. These topics were addressed through both group and individualized sessions. The training program included reading the book, *Your Perfect Right: Assertiveness and Equality in Your Life and Relationships,* by Alberti and Emmons (2008). In addition, participants participated in video reviews, discussion, role plays, writing exercises, and homework. An efficacy research study of this program showed that individuals participating in the assertiveness training reported significantly higher assertiveness responses in both general and disability-related interactions (Glueckauf & Quittner, 1992).

An outpatient treatment program for individuals with bulimic disorders combined behavioral therapy with assertive training and self-esteem enhancement. The program consisted of 10 1-hour sessions held weekly. Each group consisted of three to six patients. The psychoeducation topics included: (a) diet and eating behavior and lifestyle; (b) cognitive restructuring regarding their dieting and body shaping and behavioral therapy for acquiring a healthy diet and lifestyle; (c) assertiveness training for coping with interpersonal problems; (d) social-skills training based on problem-solving therapy; and (e) self-esteem enhancement. This study demonstrated that the treatment program resulted in less binge-eating behavior and improved social function of patients with eating disorders (Shiina et al., 2005).

A study that assessed the relationships of assertiveness, depression, and social support among 50 older nursing home residents found a significant correlation between assertiveness and depression. The subjects in this study were older adults (mean age 75), 75% female and 95% Caucasian, free of cognitive impairments. Several measures were administered, including the Wolpe-Lazarus Assertiveness Scale (WLAS), the Geriatric Depression Scale (GDS), and the Social Support List of Interactions (SSL12-I). Correlations between the mean scores were completed. The most significant findings were the correlations between assertiveness and depression, and between overall physical health and depression. Despite limitations, this study supports the use of interventions designed to increase assertiveness and improve physical health among nursing home residents as a strategy for reducing depression (Segal, 2005). Similar methods were used in a study completed with 100 older adults in a rehabilitation facility (Hersen & Kabacoff, 1995). Study results supported similar findings regarding the correlation between assertiveness and depression. The researchers concluded that older people with visual impairments need "new assertive response strategies to have their needs met successfully" (p. 528).

In 2005, a study to evaluate the effects of an assertiveness training program was conducted in an acute psychiatric unit of a military hospital in Taiwan (Lin et al., 2008). There were 68 subjects who participated in the study, which used a quasi-experimental design. The patients in the study were diagnosed with depression, bipolar disorder, anxiety disorder, or adjustment disorder. They were placed in an experimental group or a diagnosis-matched comparison group. The 40 patients who were in the experimental group were divided into subgroups of 5–8 individuals who participated in eight 2-hour assertiveness-training sessions conducted twice a week. The assertiveness-training sessions included: (a) an introduction to concepts of assertiveness theory and behaviors; (b) the presentation of information related to individual rights; (c) skill development related to listening and questioning behaviors; (d) definition and discussion regarding the relationship of self-esteem and assertiveness; (e) dealing with criticism; (f) the refusal of requests; (g) practicing both verbal and nonverbal assertiveness techniques; and (g) the giving of empathy and praise. The sessions included the use of various training strategies including "teaching, demonstration, feedback, role-playing, coaching, reinforcement, homework, group discussions, and self-directed learning" (Lin et al., 2008, p. 2878). The efficacy of the training was measured by assertiveness, social anxiety, and self-esteem inventories. After training, the results indicated that the experimental group subjects had a significant increase in assertiveness and a significant decrease in social anxiety. However, self-esteem did not increase significantly as a result of training, and no improvement was observed in the control group.

A study that compared views on bullying and anti-bullying interventions between middle school students (n = 285) and teachers (n = 37) was completed using quantitative and qualitative methods. The results of the study showed that both teachers and students strongly supported the teaching of assertiveness as a strategy for dealing with bullying (Crothers & Kolbert, 2004).

Research focusing on adolescents in a rural environment studied the relationship of assertiveness and alcohol use. This longitudinal preventative intervention

study collected data from 470 adolescents from the Midwest. A modified version of the Assertion Inventory (developed by Gambrill & Richey, 1975) was administered, as was the Alcohol Use Composite Index (AUCI). The results of data analysis indicated that several dimensions of assertiveness were found to have significant influence on the alcohol-use index. These findings support the use of multidimensional assertiveness training, offered over time, as a preventive intervention for adolescents residing in a rural setting (Goldberg-Lillehoj et al., 2005).

The use of assertiveness training to reduce the risk of HIV among women with severe mental illness was studied by Weinhardt, Carey, Carey, and Verdecias (1998). This study focused on "sexual assertiveness" training. Twenty female outpatients with primary diagnosis of schizophrenia, bipolar disorder, and major depressive disorder were screened using the HIV-Risk Behavior Screening Instrument (HRBS). Once admitted to the assertiveness program the subjects received 10 treatment sessions during a two-week period, cofacilitated by a male and a female. Sessions included HIV information, condom use, sexual assertiveness (negotiation of condom use with resistant partners and refusing to engage in unsafe sexual behaviors). Sessions focused on education and skill development. The results of this study found that women who participated in the sexual assertiveness program improved their sexual assertiveness skills through the 4-month follow-up and indicated an increased frequency of protected sex at a 2-month follow-up.

Studies related to older adults have supported the use of assertiveness in the context of receiving health-related services. In general, older adults are less assertive than the younger population because of their unfamiliarity with assertive behavior and due to their loss of confidence in using an assertive approach. After studying several conversation scenarios within a healthcare context, it was determined that assertiveness can be a positive option for older adults to utilize when communicating with their physician or other healthcare professionals (Ryan, Anas, & Friedman, 2006).

Whether designed as a separate intervention or as part of a larger program of leisure education, social-skills development, and/or anger management, assertiveness training has application as a TR intervention with a number of different client populations in a variety of practice settings.

Application to Therapeutic Recreation

The concept of assertiveness training has been described as being founded in behavioral therapy (Austin, 2004), cognitive-behavior therapy, and social-cognitive theory (Goldberg-Lillehoj, Spoth, & Trudeau, 2005). It involves behavioral, cognitive, affective, and social aspects (Moore, Hudson, & Smith, 2007) and occurs within a context that is influenced by the environment (Goldberg-Lillehoj, Spoth, & Trudeau, 2005; Ruben & Ruben, 1989). Assertiveness training reflects aspects of behavior when clients are able to express their emotions and needs in specific situations and can utilize behaviors that enhance communication and establish positive interpersonal skills. The cognitive and affective aspects of assertiveness are reflected when clients are able to express and react to positive and negative emotions without excessive anxiety and/or aggression (Colter & Guerra, 1976; Moore et al., 2007). The development of assertive response skills occurs within a social context and is influenced by a dynamic environment.

Therapeutic recreation services commonly utilize interventions that are founded in cognitive-behavioral and social-cognitive theory to address the various needs of the clients. In fact these theories are the basis for commonly used therapeutic recreation (TR) interventions such as leisure education/counseling, social skills development, and stress management (Austin, 2004; Malkin & Kastrinos, 1997; Shank & Coyle, 2002).

Therapeutic recreation practitioners often focus on the clients' social interaction skills as an important aspect of leisure participation and quality of life (Stumbo & Peterson, 2009; Carter, Van Andel, & Robb, 2003). Social interaction as a construct is comprised of several aspects, including: communication skills, relationship-building skills, and self-presentation skills (Stumbo & Peterson, 2009). Many clients served in TR have difficulties with aspects of social interaction, and these difficulties are often addressed through interventions such as leisure education/counseling, social skills programs, community reintegration programs, and anger management (Austin, 2004; Carter et al., 2003). Given the focus of assertiveness training in the development of communication skills, relationship skills, and self-presentation skills, AT appears as a viable option for TR intervention (Austin, 2004; Glueckauf & Quittner, 1992; Malkin & Kastrinos,1997; Shank & Coyle, 2002).

Although somewhat varied dependent on the characteristics of the population being served, the process of conducting assertiveness training programs utilizes

several common approaches. The "typical" assertiveness training program includes an introduction of the key concepts of assertive, passive, aggressive, and passive-aggressive behaviors/responses. These concepts are defined and the verbal and nonverbal aspects of these concepts introduced. This introductory information is typically presented using readings, worksheets, discussions, and/or video examples. This introduction leads to the identification of specific situations in which the clients might use these behaviors/responses to improve communication, enhance self-esteem, and/or decrease anxiety. It is important that the clients apply the concepts to situations that are "real" for them. The clients are also exposed to the consequences of using the various behaviors/responses in specific situations. Although the assertive behavior/response is generally preferred, clients are shown that behavioral responses are a choice and that sometimes no response is the best response. This notion is sometimes referred to as "selective assertion" (Dombeck & Wells-Moran, 2006; Doty, 1987).

Typically, assertive behaviors/responses are practiced in carefully designed role-playing that includes feedback from the therapist to the client. These role plays can be videotaped for more careful analysis and detailed feedback. Eventually, practice in the community or in "real life" situations usually occurs and the client evaluates his or her behavior/responses as part of "homework" and/or "self-assessment" (Austin, 2004; Hermes, 1998; Kolb, 1985; Paterson, 2000). Given the complexity of learning and applying assertiveness behaviors/responses, it is recommended that training be "tailored to the needs of specific participants and situations they find particularly challenging" ("Assertiveness Training," 2003). It is also important to note that assertive responses learned in a training environment are not automatically generalized to different situations (Doty, 1987; Ruben & Ruben, 1989).

The research on assertiveness training supports the use of a group format for assertiveness training over the individual approach (Lange & Jakubowski, 1978; Laxton, Gray, & Watts, 1997; Lin et al., 2008). The group format provides the opportunity for participants to practice assertiveness techniques with others and to share feedback that will reinforce the continued use of assertive responses (Lin et al., 2008). The frequency of assertiveness training sessions and the duration of sessions will depend on the needs of clients, setting of service, and resources available to the leader. It is generally recommended that sessions be held once or twice a week with time in between sessions for clients to complete "homework" and/or practice skills (Hermes, 1998).

As noted previously, assertiveness training can be a valuable TR intervention for clients who have difficulty expressing their needs, clients who could benefit from increased self-esteem, clients who have difficulty with interpersonal relationships, clients whose anxiety levels limit their satisfaction with social situations, and/or clients who lack skills in other areas of social interaction. However, participation in assertiveness training does not guarantee that clients will be successful in using these skills in all environments or that their assertive behavior/response will produce the outcomes they desire. This important point reinforces the need for therapists to discuss/practice the consequences of choosing assertive behaviors/responses so that clients are prepared for unexpected outcomes ("Assertiveness Training," 2003; Brecklin & Ullman, 2005; Dombeck & Wells-Moran, 2006; Doty, 1987).

Summary

- Assertiveness can be described as a trait, a behavior style, a communication style, and as a skill.
- Behaviors are usually sorted into assertive, aggressive, passive, and sometimes passive-aggressive. Assertive is preferred, as it expresses one person's right, but not at the expense of the other person's rights.
- Assertiveness training is appropriate for a number of client groups, such as individuals with physical disabilities, at-risk youth, marginalized groups, individuals with substance addictions, and older adults.
- Most assertiveness training programs include topics such as definitions (see the second bullet above), emotions, and communication skills, practiced through role-plays, simulations, independent practice, and group training.
- Research on assertiveness training indicates that most programs are effective in increasing participants' skill levels, which may further decrease social anxiety and improve self-esteem for some groups.
- Assertiveness skills are often taught in therapeutic recreation programs within larger social-skills training programs.
- There are many assertiveness training resources available for purchase or online.

Resources

Assertiveness: Practical Skills for Positive Communication. (1998). [Workbook and accompanying video]. By Hermes. Hazelden Publishing.

Life Management Skills I, II, & II. (1993–1994). By Korb-Khalsa & Leutenberg. The Guidance Group. www.idyllarbor.com

The Assertiveness Workbook. (2000). By Paterson. New Harbinger Publishers, Inc.

The Complete Idiot's Guide to Assertiveness. (1997). By Davidson. Alpha Books.

Listen to Me, Listen to You. (2007). By Kotzman & Kotzman. Penguin Books.

Your Perfect Right: Assertiveness and Equality in your Life and Relationships. (2001). By Alberti & Emmons. Impact Publishers, Inc.

Example Activities

Self-Assessment of Communication Styles. (1998). By Hermes.

- Checklist for identifying individual's communication style (passive, assertive, aggressive)
- Results in a score that identifies your predominant style
- Self-assessment results can be used to set goals and/or to facilitate discussion

Barriers to Assertiveness Worksheet. (2007). By Kotzman & Kotzman.

- Worksheet with questions related to the barriers to assertion
- Completed worksheet can guide discussion related to reducing these barriers

Assertiveness Scorecards. (2000). By Paterson.

- The scorecard provides an outline for recording challenging situations that one might encounter and helps one to commit to using assertive behaviors
- Can be reproduced for ongoing use as new situations arise

References

Alberti, R. E., & Emmons, M. L. (2008). *Your perfect right: Assertiveness and equality in your life and relationships* (9th ed.). Atascadero, CA: Impact Publishers, Inc.

Assertiveness Training. (2003). In *Encyclopedia of mental disorders* [Web]. Gale Cengage. Retrieved Jan 1, 2009, from: http://www.enotes.com/mental-disorders-encylopedia

Austin, D. (2004). *Therapeutic recreation: Processes and techniques* (5th ed.). Champaign, IL: Sagamore.

Bedell, J. R., & Lennox, S. S. (1996). *Handbook for communication and problem-solving skills training*. New York, NY: John Wiley & Sons.

Brecklin, L. R., & Ullman, S. E. (2005). Self-defense or assertiveness training and women's responses to sexual attacks. *Journal of Interpersonal Violence, 20*(6), 738–762.

Carter, M. J., Van Andel, G., & Robb, G. (2003). *Therapeutic recreation: A practical approach* (3rd ed.) Prospect Heights, IL: Waveland Press.

Clark, C. (2000). *Integrating complementary health procedures into practice*. New York, NY: Springer.

Colter, S. B., & Guerra, J. J. (1976). *Assertion training: A humanistic-behavioral guide to self-dignity*. Champaign, IL: Research Press.

Crothers, L. M. & Kolbert, J. B. (2004). Comparing middle school teachers' and students' views on bullying and anti-bully interventions. *Journal of School Violence, 3*(1), 17–32.

Davis, C. (1998). *Patient practitioner interaction: An experiential manual for developing the art of health care* (3rd ed.). Thorofare, NJ: SLACK, Inc.

Davidson, J. (1997). *The complete idiot's guide to assertiveness*. New York, NY: Alpha Books.

Dombeck, M., & Wells-Moran, J. (2006). Setting boundaries appropriately: Assertiveness training. Retrieved December 12, 2008, from: http://www.mentalhelp.net

Doty, L. (1987). *Communication and assertion skills for older persons*. Washington, DC: Hemisphere Publishing.

Douglas, R. R. (1980). Assertiveness training for emotionally disturbed clients. *Journal of Rehabilitation, 46*(1), 46–47.

Enns, C. Z. (1992). Self-esteem groups: A synthesis of consciousness-raising and assertiveness training. *Journal of Counseling & Development, 71*, 7–13.

Gambrill, E. D., & Richey, C. (1975). An assertion inventory for use in assessment and research. *Behavior Therapy, 6*(4), 550–561.

Goldberg-Lillehoj, C. J., Spoth, R., & Trudeau, L. (2005). Assertiveness among young rural adolescents: Relationship to alcohol use. *Journal of Child & Adolescent Substance Abuse, 14*(3), 39–68.

Glueckauf, R. L., & Quittner, A. L (1992). Assertiveness training for disabled adults in wheelchairs: Self-report, role-play, and activity pattern outcomes. *Journal of Consulting and Clinical Psychology, 60*(3), 419–425.

Hargie, O., Saunders, C., & Dickson, D. (1994). *Social skills in interpersonal communication*. New York, NY: Routledge.

Heinemann, A. (Ed.). (1993). *Substance abuse and physical disability*. Philadelphia, PA: Haworth Press.

Hermes, S. (1998). *Assertiveness: Practical skills for positive communication*. Center City, MN: Hazelden.

Hersen, M., Kabacoff, R. I., Van Hasselt, V. B., Null, J. A., Ryan, C. F., Melton, M. A., & Segal, D. L. (1995). Assertiveness, depression, and social support in older visually impaired adults. *Journal of Visual Impairment & Blindness, 89*(6), 524–531.

Jakubowski-Spector, P. (1973). Facilitating the growth of women through assertive training. *The Counseling Psychologist, 4*(1), 75–86.

Kim, Y. (2003). The effects of assertiveness training on enhancing the social skills of adolescents with visual impairments. *Journal of Visual Impairments & Blindness, 97*(5), 285–298.

Kolb, C. (1985). Assertiveness training for women with visual impairments. In M. J. Deegan & N. Brooks (Eds.), *Women & disability: The double handicap* (pp. 87–94). Edison, NJ: Transaction.

Kotzman, A., & Kotzman, M. (2007). *Listen to me, listen to you*. New York, NY: Penguin.

Lange, A., & Jakubowski, P. (1978). *The assertive option*. Champaign, IL: Research Press.

Laxton, M., Gray, C. J., & Watts, S. M. (1997). Teaching assertiveness skills to people with learning disabilities: A brief report of a training programme. *Journal of Intellectual Disabilities, 1*(2), 71–76.

Lin, Y., Wu, M., Yang, C., Chen, T., Hsu, C., Chang, Y., et al. (2008). Evaluation of assertiveness training for psychiatric patients. *Journal of Clinical Nursing, 17*(21), 2875–2883.

Malkin, M., & Kastrinos, G. (1997). Integration of cognitive therapy techniques with recreational therapy. In D. M. Compton (Ed.), *Issues in therapeutic recreation: Toward the new millennium* (2nd ed.) (pp. 445–460). Champaign, IL: Sagamore.

Meyer, L. (1999). People with disabilities and abuse. Retrieved January 10, 2009, from: http://www.ilru.org/html/publications/readings_in_IL/abuse.html

Moore, K. A., Hudson, E. E., & Smith, B. F. (2007). The relationship between assertiveness and social anxiety in college students. *Undergraduate Research Journal for the Human Sciences, 6*, Article 0000001016. Retrieved on August 8, 2008, from: http://www.kon.org/ure/v6/moore.html

Nezu, C. M., Nezu, A. M., & Arean, P. (1991). Assertiveness and problem-solving training for mildly mentally retarded persons with dual diagnoses. *Research in Developmental Disabilities, 12*, 371–386.

Page, E. C., Holland, B., Rand, M. E., Gartin, B. C., & Dowling, D. A. (1981). Assertiveness training groups with the disabled: A pilot study. *Journal of Rehabilitation, 47*(2), 52–55.

Paterson, R. J. (2000). *The assertiveness workbook*. Oakland, CA: New Harbinger.

Ruben, D. H. & Ruben, M. J. (1989). Why assertiveness training programs fail. *Small Group Behavior, 20*(3), 367–380.

Ryan, E. B., Anas, A. P., & Friedman, D. B. (2006). Evaluations of older adult assertiveness in problematic clinical encounters. *Journal of Language and Social Psychology, 25*, 129–145.

Salter, A. (1949). *Conditioned reflex therapy: A direct approach to reconstruction of personality* (1st ed.). New York, NY: Creative Age Press.

Salter, A. (2002). *Conditioned reflex therapy: A direct approach to the reconstruction of personality* (50th anniversary printing). Gretna, LA: Wellness Institute, Inc.

Segal, D. (2005). Relationships of assertiveness, depression, and social support among older nursing home residents. *Behavior Modification, 29*(4), 689–695.

Shank, J., & Coyle, C. (2002). *Therapeutic recreation in health promotion and rehabilitation*. State College, PA: Venture Publishing, Inc.

Shannon, J. W. (1999). Teaching children healthy responses to anger with assertiveness training. *Brown University Child and Adolescent Behavior Letter, 15*(7), 1–3.

Shiina, A., Nakazato, M., Mitsumori, M., Koizumi, H., Shimizu, E., Fujisaki, M., et al. (2005). An open trial of outpatient group therapy for bulimic disorders: Combination program of cognitive behavioral therapy with assertive training and self-esteem enhancement. *Psychiatry and Clinical Neurosciences, 59*(6), 690–696.

Smith, M. J. (1975). *When I say no, I feel guilty*. New York, NY: Bantam Books.

Stumbo, N. J., & Peterson, C. A. (2009). *Therapeutic recreation program design: Principles and procedures* (5th ed.). San Francisco, CA: Pearson Benjamin Cummings Publishing.

Ticoll, M. (1994). *Family violence prevention unit*. Ottawa, Ontario: National Clearinghouse on Family Violence.

Weinhardt, L. S., Carey, M. P., Carey, K. B., & Verdecias, R. N. (1998). Increasing assertiveness skills to reduce HIV risk among women living with a severe and persistent mental illness. *Journal of Consulting and Clinical Psychology, 66*(4), 680–684.

Winterowd, C., Beck, A.T., & Gruener, D. (2003). *Cognitive therapy with chronic pain patients*. New York, NY: Springer.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.

Wolpe, J., & Lazarus, A. (1966). *Behavior therapy techniques: A guide to the treatment of neuroses*. Oxford, UK: Pergamon Press.

Zelik, L. (1984). The use of assertiveness training with chronic pain patients. In Cromwell, F. (Ed.), *Occupational therapy and the patient with pain* (pp. 109–118). New York, NY: Routledge.

Reading Material from:

Stumbo, N.J. & Wardlaw, B. (2011). Facilitation of therapeutic recreation services: An evidence-based and best practice approach to techniques and processes. State College, PA: Venture Publishing